CMS Manual System

Pub 100-08 Medicare Program Integrity

Transmittal 131

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: NOVEMBER 10, 2005

CHANGE REQUEST 4052

SUBJECT: Medical Review Matching of Electronic Claims and Additional Documentation in the Medical Review Process

I. SUMMARY OF CHANGES: Clarifies that for medical review contractors cannot require the submission of paper claims except as expressly permitted in chapter 24, section 90, of the Medicare Claims Processing Manual. Clarifies how to treat claims and paper documentation for medical review purposes. Indicates when additional documentation shall be matched or considered for medical review.

NEW/REVISED MATERIAL

EFFECTIVE DATE: February 10, 2006

IMPLEMENTATION DATE: February 10, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:

R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/4.1.1/Documentation Specifications for Areas Selected for Prepayment or Postpayment MR
R	3/5/Prepayment Review of Claims for MR Purposes

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-08	Transmittal: 131	Date: November 10, 2005	Change Request 4052

SUBJECT: Medical Review Matching of Electronic Claims and Additional Documentation in the Medical Review Process

I. GENERAL INFORMATION

A. Background: The Administrative Simplification Compliance Act requires that all Medicare claims be submitted electronically with only a few limited exceptions. Those exceptions are outlined in chapter 24, section 90, of the Medicare Claims Processing Manual.

B. Policy: Not all contractors have the capability of matching electronic claims to paper supporting documentation. Given that limitation, this CR provides instructions to all contractor medical review areas on how to treat claims and paper documentation for medical review purposes.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4052.1	Contractors shall not require providers who have been selected for prepayment medical review to submit paper claims.	X	X	X	X					PSCs performing prepay medical review
4052.2	Contractors shall allow providers that qualify for an electronic billing exemption to submit paper claims when they are targeted for medical review.	X	X	X	X					PSCs performing prepay medical review
4052.3	Supporting documentation shall be solicited only through the additional documentation request (ADR) process or alternate contractor process that permits matching for medical review.	X	X	X	X					PSCs performing prepay medical review

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4052.4	Contractors shall not require or request from any provider submission of supporting documentation with the initial claims, through the use of contractor developed forms, local policies, or other communication.	X	X	X	X					PSCs performing prepay medical review
4052.5	Unsolicited supporting documentation shall be matched or considered only at the contractors' discretion.	X	X	X	X					PSCs performing prepay medical review
4052.6	If a contractor chooses to allow supporting paper documentation to be submitted with the claim for medical review purposes the contractor shall inform providers in their jurisdiction of that fact.	X	X	X	X					PSCs performing prepay medical review
4052.7	Only if identified as a prioritized problem in your medical review strategy, and when consistent with section 11.1.1, of the PIM, contractors shall, at their discretion, choose to suspend to medical review lab services with one of the laboratory negotiated rulemaking ICD-9 "Codes that Do Not Support Medical Necessity (where documentation could result in payment)".	X	X	X	X					PSCs performing prepay medical review
4052.8	In the situation described in 4052.7 above, contractors shall continue to use the documentation submitted with the claim in order to make their determination whether the lab service was reasonable and necessary for that particular ICD-9 code.	X	X	X	X					PSCs performing prepay medical review
4052.9	Contractors shall continue to follow the instructions found at section 3.4.1.2.B, of the PIM when requesting additional documentation in order to perform medical review of laboratory claims.	X	X	X	X					PSCs performing prepay medical review

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4052.10	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X					PSCs performing prepay medical review

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: February 10. 2006 **Implementation Date:** February 10, 2006 **Pre-Implementation Contact(s):** Dan Schwartz (daniel.schwartz@cms.hhs.gov) or Kevin Kwon (Kevin.kwon@cms.hhs.gov) **Post-Implementation Contact(s):** Your regional office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

3.4.1.1 - Documentation Specifications for Areas Selected for Prepayment or Postpayment MR

(Rev. 131, Issued: 11-10-05; Effective: 02-10-06; Implementation: 02-10-06)

The contractor may use any information they deem necessary to make a prepayment or postpayment claim review determination. This includes reviewing any documentation submitted with the claim as well as soliciting documentation from the provider or other entity when the contractor deems it necessary and in accordance with PIM, chapter 3, §3.4.1.2.

A. Review of Documentation Submitted with the Claim

If a claim is targeted based on data for prepayment or postpayment medical review (including automated, routine, or complex) contractors may review unsolicited supporting documentation accompanying the claim, but are not required to do so.

There are two exceptions to this rule. Contractors may deny without reviewing attached or simultaneously submitted documentation (1) when clear policy serves as the basis for denial, and (2) in instances of medical impossibility (see PIM, chapter 3, §3.5.1).

***NOTE:** The term "clear policy" means a statute, regulation, NCD, coverage provision in an interpretive manual, or LCD that specifies the circumstances under which a service will always be considered non-covered or incorrectly coded. Clear policy that will be used as the basis for frequency denials must contain utilization guidelines that the contractor considers acceptable for coverage.*

If a contractor chooses to allow supporting paper documentation to be submitted with the claim for medical review purposes the contractor shall inform providers in their jurisdiction of that fact (see PIM, chapter 3, §3.5).

B. Signature Requirements

Medicare requires a legible identifier for services provided/ordered. The method used (e.g., hand written, electronic, or signature stamp) to sign an order or other medical record documentation for medical review purposes in determining coverage is not a relevant factor. Rather, an indication of a signature in some form needs to be present. Do not deny a claim on the sole basis of type of signature submitted.

Providers using alternative signature methods (e.g., a signature stamp) should recognize that there is a potential for misuse or abuse with a signature stamp or other alternate signature methods. For example, a rubber stamped signature is must less secure than other modes of signature identification. The individual whose name is on the alternate signature method bears the responsibility for the authenticity of the information being attested to. Physicians should check with their attorneys and malpractice insurers in regard to the use of alternative signature methods.

All State licensure and State practice regulations continue to apply. Where State law is more restrictive than Medicare, the contractor needs to apply the State law standard. The signature requirements described here do not assure compliance with Medicare conditions of participation.

Note that this instruction does not supersede the prohibition for Certificates of Medical Necessity (CMN). CMNs are a term of art specifically describing particular Durable Medical Equipment forms. As stated on CMN forms, "Signature and date stamps are not acceptable" for use on CMNs. No other forms or documents are subject to this exclusion.

C. Review of Documentation Solicited After Claim Receipt

The process whereby a contractor requests additional documentation after claim receipt is known as "development." Providers selected for review are responsible for submitting medical records requested of them by the contractor within established timeframes. Development requirements are listed below in section 3.4.2.1.

D. Requirements That Certain Tests Must Be Ordered By The Treating Physician

Effective November 25, 2002, 42 CFR 410.32(a) requires that when billed to any contractor, all diagnostic x-ray services, diagnostic laboratory services, and other diagnostic services must be ordered by the physician who is treating the beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem.

E. Diagnosis Requirements

Section 1833(e) of the Act provides that no payment may be made "under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person . . ."Contractors may require information, in accordance with the requirements below whenever they deem necessary to make a determination listed in section 3.4.1 and thus to determine appropriate payment.

Some provider types are required to submit diagnosis codes on all claims while other provider types are required to submit diagnosis codes only if such information is required by an *LCD.*

- Claims Submitted by Physicians or **§1842(b)(18)(C) of the Act** Practitioners Must Contain Diagnosis Codes

Section 1842 (p)(1) of the Act states that each claim submitted by a physician or §1842(b)(18)(C) of the Act practitioner "shall include the appropriate diagnosis code (or codes)…". For services from physicians and §1842(b)(18)(C) of the Act practitioners submitted with an ICD-9 code that is missing, invalid, or truncated, contractors must return the billed service to the provider as unprocessable in accordance with MCM §3005.4(p) or MIM §3605.3.

- Claims Submitted By All Other Provider Types Must Contain Diagnosis Codes If Such Codes Are Required By An *LCD* (effective 7/1/02)

In order to address potential abuse or overutilization, contractors can require that ICD-9 diagnosis codes be submitted with each claim for the targeted service. This information is used in determining whether the services are covered and correctly coded. Effective April 1, 2002, contractors may require ICD-9 diagnosis codes to be submitted by all non-physician billers with every claim for a targeted service only if such a requirement appears in an *LCD* for that service. Contractors must educate providers about this requirement beginning no later than January 1, 2002. This outreach should occur via website bulletin articles, etc.

For individual non-physician providers who are identified due to unusual billing practices, fraud referrals, etc., contractors may also require ICD-9 diagnosis codes to support the medical necessity of all or some claims submitted by the targeted entities, even if no *LCD* exists requiring such codes.

For services submitted with an ICD-9 diagnosis code that is missing, incorrect or truncated as indicated above, contractors must return the billed service to the provider as unprocessable.

F. Requirements for Lab Claims

The American Medical Association's (AMA) 1998 edition of the Current Procedural Terminology (CPT) established three new and one revised Organ or Disease Oriented laboratory panels. Since these panels are composed of clinically relevant groupings of automated multichannel tests there is a general presumption of medical necessity. If there is data or reason to suspect abuse of the new panel codes, contractors may review these claims. Should contractors determine the need to develop a *LCD* for laboratory panel codes, develop these policies at the panel code level. In some instances of perceived abuse of the new panel codes, you may review the panel and deny component tests on a case-by-case basis or evaluate the need for the component level test.

3.5 - Prepayment Review of Claims for MR Purposes

(Rev. 131, Issued: 11-10-05; Effective: 02-10-06; Implementation: 02-10-06)

The instructions listed in this section (section 3.5) apply only to reviews conducted for MR purposes unless otherwise noted.

Contractors may not initiate non-random prepayment review of a provider or supplier based on the initial identification by that provider or supplier of an improper billing practice unless there is a likelihood of a sustained or high level of payment error. For more information regarding identifying providers or suppliers with a sustained or high level of payment errors please refer to chapter 3, section 11, of this manual.

Claims

The Administrative Simplification Compliance Act (ASCA, Section 3 of Pub. L. 107-105, 42 CFR 424.32) requires that all Medicare claims be submitted electronically with only a few limited exceptions. Accordingly, contractors shall not require providers to submit paper claims when they are targeted for prepayment complex medical review. Contractors must, however, allow providers that qualify for an ASCA mandatory electronic billing exception to submit paper claims when they are targeted for prepayment review (see chapter 24, section 90, of the Medicare Claims Processing Manual for exceptions).

Supporting Documentation

Contractors may not require or request, from any provider regardless of size, the submission of supporting documentation with the initial claim(s) through contractor developed forms, local policies, or any other communications with providers. Supporting documentation may only be requested through the Additional Documentation Request (ADR) process or alternate contractor process that permits matching.

Contractors shall associate supporting documentation with claims as a part of the on-going medical review process. Unsolicited supporting documentation submitted outside of the ADR process may be considered at the contractors' discretion, but contractors cannot require paper claims as a way to match documentation. If a contractor chooses to allow supporting paper documentation to be submitted with the claim for medical review purposes the contractor shall inform providers in their jurisdiction of that fact.

Only if identified as a prioritized problem in their medical review strategy, and when consistent with section 11.1.1, of the PIM, contractors may choose to suspend to medical review lab services with one of the laboratory negotiated rulemaking ICD-9 "Codes that Do Not Support Medical Necessity (where documentation could result in payment)". In these cases, contractors shall continue to use the documentation submitted with the claim in order to make their determination whether the lab service was reasonable and necessary for that particular ICD-9 code. Contractors shall continue to follow the

instructions found at section 3.4.1.2.B, of the PIM when requesting additional documentation in order to perform medical review of laboratory claims.